MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes () No
Requestor's Name and Address J. A. McNally, M.D. 4275 Little Rd. #202 Arlington, Texas 76016	MDR Tracking No.: M4-04-3163-01
Respondent's Name and Address Lumbermens Mutual Casualty Company % Gallagher Bassett Services, Inc. 16414 San Pedro Ave Ste. 400 San Antonio, Texas 78232 Box #19	Employer's Name: Quanta Services, Inc. Insurance Carrier's No.: 001560001728WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
6/19/03	**6/19/03**	**00670-P3**	**$40.00**	**$40.00**

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor 's position statement states in part, "…Carrier has refused to reimburse for the P3 modifier because the patient is a smoker with chronic bronchitis which causes additional risk for anesthesia…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Carrier's position statement states in part, "…The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Requestor billed using CPT code 00670 with a P3 modifier. The MAR for this CPT code with modifier is $800.00. The Carrier denied additional reimbursement as "F – Fee Guideline MAR reduction". The Requestor's documentation supports the modifier billed. The Requestor billed according to the 1996 Medical Fee Guideline, Anesthesia Ground Rule (I). Additional reimbursement is recommended in the amount of $40.00 (13 RVU + 6 TAV + 1 modifier unit = 20 units; $40.00 x 2- units = $800.00 billed - $760.00 reimbursed by Carrier = $40.00).

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$40.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	March 3, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____